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Transitioning Medi-Cal Eligible Patients from the UCSD Student-Run Free Clinic Project to Community Health Centers in the Context of the Affordable Care Act

Abstract

Background
The Affordable Care Act was implemented in 2014 and had a significant impact on the affordability and accessibility of healthcare for medically underserved populations within the United States (20). The UCSD Student-Run Free Clinic provides free and comprehensive medical care to underserved patients in San Diego County. The Free Clinic prioritizes providing healthcare to uninsured patients (12). Some Free Clinic patients gained insurance through the Affordable Care Act, and a subset of these insured patients continue to be cared for at the Free Clinic. Literature review suggested that patient navigators would be useful in helping these patients utilize their insurance and transition care to new medical homes.

Methods
To achieve this goal, a new managerial position, the Medi-Cal Transitions Manager, was created at Free Clinic. As Medi-Cal Transitions Managers, medical students followed a five-step protocol (please see Appendix) to ensure a seamless transfer of care from the Free Clinic to Federally Qualified Health Centers and other Medi-Cal accepting clinics in San Diego County.

Results
During the initial pilot phase, Medi-Cal Transitions Managers have helped four patients transition from Free Clinic to new medical homes. These managers encountered several significant challenges, which are discussed. Some potential solutions are discussed as well.

Conclusions
With some modifications in the protocol to address the aforementioned challenges, the Medi-Cal Transitions Managers can continue to be a valuable asset to Free Clinic patients and the Free Clinic as an institution. However, the Affordable Care Act has recently faced significant legislative attacks, and the accessibility of healthcare for patients insured through this program may be compromised. This could have a disproportionately significant impact on the underserved patient population cared for at the Free Clinic, past and present.

I. ACA for Low-Middle Income Individuals without Employer-Provided Insurance

Implemented on January 1, 2014, the Patient Protection and Affordable Care Act (ACA) aims to provide Americans with increased access low-cost, high-quality healthcare. Spanning 955 pages, the ACA is a large and complex piece of legislation with wide-ranging effects. However, there are two primary means by which the ACA helps low to middle-income individuals without employer-provided insurance access affordable healthcare. The first is an expansion of Medicaid coverage to include households earning up to 138% of the federal poverty level (FPL). The second is the creation of American Health Benefit Exchanges, statewide marketplaces in which private insurers compete to sell subsidized insurance policies to Americans earning up to 400% of the FPL [20].

As implemented, eligible individuals or households receive financial assistance for purchasing insurance policies on the Health Insurance Exchanges via two methods. The first is an advanceable federal tax credit, available to consumers with household incomes up to 400% of the FPL. The second are Cost-Sharing Reductions (CSR), federal subsidies paid to insurers on behalf of individuals with household incomes between 138% and 250% of the FPL. These subsidies are distributed on a sliding scale basis, depending on household income [20, 3, 8].

Each state will have one of four types of Health Insurance Exchange. The degree of state verses federal involvement with the implementation and maintenance of said marketplaces determines marketplace categorization. The four categories are as follows, listed in descending order of state involvement: State-based Marketplace, State-based Marketplace-Federal Platform, State-Partnership Marketplace, and Federally-facilitated Marketplace [18]. In general, liberal states tend to have greater marketplace involvement than their conservative counterparts. For instance, Colorado has a State-based Marketplace, whereas Texas has a Federally-facilitated Marketplace.

There are several additional components of the ACA affecting low to middle-income individuals without employer-provided insurance that warrant mention.

They are as follows: the Individual Mandate, the Employer Shared Responsibility Provision, and the Small Business Health Options Program (SHOP).

The Individual Mandate is a requirement for American citizens and legal residents to have health insurance coverage. Those who are not in compliance risk an annual penalty of $695 or 2.5% of total income, whichever is greater [20]. The purpose of the Individual Mandate is to lower the overall risk-pool of the insured cohort by incentivizing participation of younger, healthier individuals. It is probably the most fiercely contested component of the ACA.

Both the Employer Shared Responsibility Provision and SHOP aim to increase the quality and quantity of employer-provided health insurance policies. The Employer Shared Responsibility Provision requires applicable large employers, defined as businesses with an excess of 50 or more full-time employees, to automatically enroll employees in qualifying health insurance policies. Applicable large employers that fail to comply will be faced with monetary penalties. Small businesses, defined as those with less than 50 full-time employees, are not required to provide health insurance coverage. However, with the ACA, small businesses can qualify for assistance in insuring employees in the form of federal tax credits by participating in SHOP. SHOP is to be implemented January 1, 2018 [16,20].

II. Effects of the ACA Nationwide and in California

To date, it is estimated that the ACA has helped over 20 million Americans gain health insurance. Of these, 10 million gained insurance through ACA-enabled Medicaid expansion while many of the remaining 10 million gained insurance through policies purchased on the Health Insurance Exchanges. [17]. Despite these impressive statistics, the impact of the ACA has not been evenly distributed. At the time of writing, 18 states have refused to participate in ACA-enabled Medicaid expansion [19]. A 2017 study by Sommers, Maylone, Blendon, et al of the Harvard T. H. Chan School of Public Health compared prevalence of insurance in Kentucky, which expanded Medicaid, against Texas, which did not. Prior to the ACA, both states had an uninsured rate of approximately 40% among low-income adults. By 2016, the rate had dropped to 7.4% in Kentucky verses 28.2% in Texas. Perhaps not

surprisingly, Medicaid expansion was associated with increased rates of outpatient encounters with an established primary care physician and decreased rates of emergency department visits. Rates of glucose and cholesterol monitoring, the study's two measures of clinical screening tests, increased significantly more in Kentucky than Texas, but overall rates of hospitalizations did not change in either state [17].

Legislatively, California embraced the ACA by participating in the expansion of Medicaid (known as Medi-Cal in California) and establishing a State-based Marketplace. Prior to the ACA, 6 million, or 16.4%, of adult Californians were uninsured [4]. Of those, 2.5 million were eligible but not enrolled in Medi-Cal, and another 1.4 million gained eligibility for Medi-Cal with the ACA-funded expansion of coverage [11]. It is estimated that over half of these previously uninsured individuals have gained insurance since the rollout of the ACA, lowering the total population of uninsured adults in California to 2.9 million [1]. Of those that remain uninsured in California, 1 in 3 are ineligible for insurance through the ACA due to citizenship status. Many of the patients of the UCSD Student-Run Free Clinic Project, which will be discussed below, fall into this category. The others that remain uninsured cite high costs or lack of need as the primary reasons for abstaining [1].

Finally, evidence suggests that the ACA has helped to reduce racial and ethnic disparities in insurance coverage. J. Heintzman et al of the Oregon Health and Sciences University compared insurance rates of patients of patients visiting community health centers in Oregon before and after the implementation of the ACA. Prior to the ACA, Spanish-preferring Latinos were more likely to be uninsured compared to English-preferring Latinos and non-Hispanic Whites. Of these three cohorts, Spanish-preferring Latinos had the largest increase in rates of insurance with the ACA. Furthermore, Heintzman et al found that the racial disparity in insurance rates within the study population was eliminated within one year of implementation of the ACA. It is worth noting that the majority of patients of the UCSD Student-Run Free Clinic are Spanish-preferring Latinos [7].

III. The UCSD Student Run Free Clinic Project

The UCSD Student-Run Free Clinic Project (Free Clinic) is a non-profit, volunteer-run clinic that provides comprehensive medical care at four sites across San Diego County. Founded in 1997 by UCSD medical students and Professor of Family Medicine Ellen Beck, the Free Clinic provides care to primarily uninsured patients that do not have access to care. The mission of the Free Clinic is to "provide respectful, empowering, high-quality health care to the underserved while inspiring the next generation of health care professionals [12]." UCSD medical students play a critical role at the Free Clinic, engaging in primary and specialty care as medical student "managers" as well as orchestrating clinic logistics. In addition to medical care, patients of the Free Clinic may receive free dental care, legal advice, social work consultations, and acupuncture treatments.

The Free Clinic serves as the primary medical home for over 650 patients [12]. However, with a population of greater than 3 million and an estimated uninsured rate of 13.25% [14], San Diego County has an enormous number of medically underserved individuals. Running on grants, donated time, and donated money, the Free Clinic is simply unable to accommodate the majority of those in need of its services. Accordingly, the Free Clinic operates at capacity and is usually able to accept new patients only when an established patient transfers care elsewhere. Because of this, the priority of the Free Clinic is "caring for patients who do not qualify for other healthcare programs or resources [12]".

IV. Patient Navigators

Many patients of the Free Clinic qualified for insurance as a result of the ACA. The vast majority of these patients gained insurance and transferred care to a new medical home. However, a small but significant portion of Free Clinic patients eligible for Medi-Cal or subsidized insurance via the Covered California Health Insurance Exchange continued to receive care at the Free Clinic. Given the aforementioned demand for care at the Free Clinic, it was imperative to help these patients utilize their benefits so that the Free Clinic could accept additional patients and assist those who might not qualify for care elsewhere.

A literature review suggested that the establishment of a patient navigator program would be an effective solution in helping this insured cohort of patients successfully transition to new medical homes. According to Harold Freeman MD, the creator of the first patient navigator program, patient navigation is a "patient-centric health care service delivery intervention, the principle purpose of which is to eliminate barriers, which may occur across the healthcare continuum [6]". The specific role of a patient navigator varies between programs and is based upon the unique needs of individual patients. While still a relatively new concept in medicine, patient navigation programs have been shown to improve healthcare outcomes in underserved populations. In Chicago, patient navigator programs have reduced the average time between abnormal cervical cancer screenings and follow up appointments from 227 days to 59 days in participating uninsured patient populations [15]. In Harlem, a patient navigator program coupled with methods of early detection helped increase 5-year breast cancer survival rates in a cohort of uninsured women from 39% to 70% [6]. In addition to improved healthcare outcomes, patient navigation has been proven to decrease the frequency of missed appointments by patients with a strong history of no-shows, increasing the efficiency of healthcare delivery [13].

V. Medical Students as Medi-Cal Transitions Managers

In accordance with the aforementioned literature review, a patient navigation program was established in the Free Clinic via the creation of a new medical student managerial position- the Medi-Cal Transitions Manager. The goal of Med-Cal Transitions Managers is to help Free Clinic patients utilize insurance benefits and seamlessly transition care to new medical homes.

Eligible patients were identified through interviews with Free Clinic primary care attending physicians as well as Free Clinic social workers. The eligible patient census, along with key patient identifying information and status notes, was compiled into a list and uploaded to iShare, a HIPPA compliant internet platform accessible to Free Clinic volunteers and employees. This list was periodically updated, and at the time of writing contains six patients.

A five-step protocol, which can be found in the Appendix, was written to ensure the quality of transfers of care. According to said protocol, Medi-Cal Transitions Managers were to interview eligible patients to determine barriers to transfer and preference for the location of new medical homes. To aid in this process, a map containing the location and contact information of Federally Qualified Health Centers and other clinics accepting Medi-Cal was made. Once a new clinic was selected, managers were to schedule an appointment at said clinic on their patient's behalf. Prior to the appointment, managers were to create a Free Clinic discharge summary to ensure a seamless medical handoff. The discharge summary is a concise report of the patient's medical history and current disease management plans analogous to discharge summaries written following hospitalizations. An example is included in the Appendix. If possible, managers were to attend the patient's first appointment at the new clinic to ensure the visit was without issues. This is an important measure to ensure logistical issues do not affect transfer. Finally, managers were to follow-up with patients via telephone to ensure continued success of transition. A brief overview of the transfer process with a specific patient may be found in the Appendix.

To date, managers have successfully achieved this goal with four patients, and continue to work with eligible patients at Free Clinic on an ongoing basis. Unfortunately, the protocol has not been strictly adhered to throughout all transitions. The importance of the protocol must be emphasized to future managers. Several additional challenges have been identified during the course of this project. The following paragraphs will identify said challenges and provide suggestions to overcome them.

The first challenge is identifying the patients who are eligible for coverage or already have coverage to pair with medical student Transitions Managers. In addition, a small number of patients who have been identified as eligible for Medi-Cal have fears about applying. Some patients who are just above the Medi-Cal income cut off fear the financial impact of their share of cost, the co-payments, or drug costs. Therefore, some patients who have become accustomed to receiving thorough primary care, specialty care, laboratory services, imaging, and supplies

free of charge simply do not wish to leave Free Clinic and resist efforts for transfer. The creation of a questionnaire probing what these patients like best about Free Clinic and what fears exist about going elsewhere could be useful in helping these patients. Having medical student transitions managers partner with social work would also be beneficial for this subset of patients.

An additional barrier is the recruitment and retention of medical students to participate as Medi-Cal Transitions Managers. This position is new and not well known by most students and does not follow the usual workflow pattern for specialty clinic manager roles in the Free Clinic. Recruitment success could perhaps be bolstered by targeting efforts on students who are already working as managers in compatible longitudinal positions and who are already on-site at clinic frequently, such as Continuity Managers or General Managers. The transitions work could supplement their pre-existing roles.

Another major challenge involves communication with monolingual Spanish-speaking patients. Medical students unable to speak Spanish may experience difficulty in speaking with these patients outside of clinical appointments, where translators are readily available. This could be addressed by having an exclusively English-speaking medical student partner with a dedicated translator or social worker when working with an exclusively Spanish-speaking patient. This could have the added benefit of increasing continuity between managers.

Finally, student availability and turnover can affect successful transition of care as the length of time required to transition a patient to an outside clinic may exceed the number of months medical students can commit to their Free Clinic managerial positions. Medical students assume managerial positions in the late winter or spring quarter of their first year of school. They are often out of town for the summer between first and second year, then return for one quarter during second year, and transition their role to first year students . These time constraints make follow up especially difficult. However, a review of medical records on EPIC does not indicate any transitions patients have returned to Free Clinic after transitioning their care elsewhere with a Transitions Manager. This challenge could also be addressed by partnering with colleagues in social work. Having a social

worker involved in a case could provide continuity and encourage progression of transfer despite medical student turnover or unavailability.

VI. ACA in 2017: Challenges to ACA and Implications

The ACA has been the subject of intense partisan debate since its conception, and the inauguration of the Trump Administration has ushered in an era of unprecedented challenges. Despite the failure of two bills aimed at overhauling the ACA, the American Health Care Act and the Better Care Reconciliation Act, 2017 dealt three major blows to the ACA: the potential defunding of CSR subsidies, the repeal of the Individual Mandate, and Executive Order 13813. The following paragraphs will briefly examine the potential impact of these challenges.

As stated previously, CSR is a federal subsidy paid directly to insurers to further reduce insurance premiums for individuals with household incomes between 138% and 250% of the FPL. In October 2017, the federal government announced that it would no longer continue to make CSR payments to insurance companies unless Congress appropriates funds. It remains unclear whether or not Congress will do so. According to a recent Kaiser Family Foundation analysis, discontinuation of CSR subsidies would require consumers to pay an average of 19% more for silver-level plans purchased on Health Insurance Exchanges [9].

Passed in December 2017, the Tax Cuts and Jobs Act contains a provision eliminating the Individual Mandate in 2019. The anticipated effect of this repeal is an exodus of young and relatively healthy individuals from the insurance pools, raising the average disease burden per patient. This will inevitably lead to an increased cost to insure each patient and a consequential increase in the price of insurance premiums. These price hikes may drive away less ill patients, further skewing the insured patient pool towards higher average disease burden and further increasing insurance premiums. This process is referred to as a “death spiral”, and could potentially continue until only the most ill patients maintain insurance plans [10].

Executive Order 13813, also known as the Executive Order Promoting Healthcare Choice and Competition, was signed in October 2017 and expands the

duration of short-term, limited duration insurance (STLDI) plans. STLDI plans had historically been limited to three-month coverage windows and used to bridge gaps in insurance coverage between jobs. They are inexpensive, but offer only limited benefits. They do not meet minimum essential coverage standards as outlined by the ACA, and therefore do not offer protection from Individual Mandate tax penalties. The Executive Order extends their coverage period from three months to one year. Coupled with the elimination of the Individual Mandate, this order incentivizes young, healthy patients to purchase STLDI plans rather than those available on the Health Insurance Exchanges. This can contribute to the aforementioned death spiral of the ACA, and is especially concerning as STLDI plans leave patients grossly underinsured [5].

It is worth noting, however, that these changes have not been fully implemented. Congress has not reached a verdict on defunding CSRs, and even if they agree to do so it is likely that insurance companies could recover these funds via litigation [2]. The elimination of the Individual Mandate is not slated to occur until 2019, by which point additional protections could be established. Finally, the constitutionality of the Executive Order is sure to be challenged in court. The ACA's death by a thousand cuts is not a certainty, which is a good thing for Free Clinic patients who qualified and continue to qualify for insurance as a result of ACA policies.

APPENDIX

A) Protocol

1. Interview
    a. You will be provided with your patient's name, date of birth, and MRN on the iShare patient list. Use this information to access the patient's chart in EPIC. From here, you can obtain the patient's phone number and view the date of their next appointment. You can interview your patient over the phone or in person at their next appointment, but the latter is the preferred method.
    b. The goal of the interview is fourfold: 1) introduce yourself to your patient, 2) assess their willingness to participate, 3) determine which barriers exist between your patient and the successful transition out of FC, 4) obtain your patient's logistical information, such as your

patient's preferred methods of communication and desired location for their new medical home.

c. Please refer to the document "motivational interviewing" on iShare for suggestions on how to counsel a patient that is ambivalent about transitioning.

2. Select a new medical home and schedule appointment
    a. Use our online map to locate a clinic for your patient. This map can be located at http://www.pinmaps.net/mymaps/#Medi-Cal username: UCSDSRFCTP password: ucsd123$
    b. Enter the desired clinic location into the search bar; locate the nearest clinics identified by "pins" on the map
        i. Green pins are "in-network" clinics- clinics at which physicians that volunteer at Free Clinic work.
        ii. Blue pins are clinics at which UCSD SOM partners with for ambulatory care apprenticeships (ACAs) that primarily care for underserved populations.
        iii. Red pins are community health centers with no formal affiliation to UCSD SRFC or UCSD SOM.
    c. Click the pin. This will reveal clinic hours and the names of the UCSD-affiliated physicians (if a green or blue clinic). You may also click the pin and then click the "more information" button to be directed to the clinic website.
    d. Call to schedule your patient's first appointment. You will need your patient's date of birth for this.
3. Create a Free Clinic discharge summary
    a. Using template provided on iShare, create a concise summary of your patient's medical record for your patient's new physician. This document ensures that none of your patient's medical issues are "lost" during the transition. Please see the attached document "FC discharge report" example on iShare.
4. Attend appointment with your patient
    a. Help your patient complete paperwork, if necessary.
    b. If your patient wishes, sit in on the office visit.
    c. Provide any follow up education and answer any questions that the patient may have after the appointment.
    d. In certain instances, patients may request that you join them for additional appointments. Limit this to three. If there is an issue with this, please reach out to Jake, Dr. Smith, or Dr. Rodriguez
5. Follow up.
    a. Make a note in EPIC indicating that your patient has transferred and the location of their new medical home.
    b. Call your patient at one, three, and five months after their initial appointment to ensure that they are happy with their new medical home.

B) Example of a Free Clinic Discharge Summary

Patient Info
Name: _____
DOB: _____
Allergies: _____
Duration of Care at FC: _____

Current medical problems
#HTN: asymptomatic essential HTN treated with 4 antihypertensives: HCTZ 25mg daily, losartan 100mg daily, amlodipine 10mg daily, and atenolol 25mg daily. Atenolol initiated in 01/2016 due to repeated BP measurements of 130/100.
#DM2: A1c of 6.5 on 11/19/2015 without symptoms. PMH significant for pre-diabetes with A1c of 6.2 in 10/14 and 5.7 in 2/15. Patient has been educated on importance of diet and exercise. Initiation of metformin considered. Needs diabetic retinopathy exam.
#Hyperlipidemia: ASCVD 10-year risk of 23.2% with most recent labs. Atorvastatin 40mg daily treatment initiated 11/2015.
#GERD: currently well controlled with ranitidine 300mg daily.
#Smoking: 30+ pack year history, motivated to quit. Has engaged with the FC smoking cessation team. Prescribed 21mg nicotine patch daily and 2mg nicotine lozenges for breakthrough craving.

Current medications
ASA 81mg daily
Amlodipine 10mg daily
Atenolol 25 mg daily
Atorvastatin 40mg daily
Hydrochlorothiazide 25mg daily
Losartan 100mg daily
Ranitidine 300mg nightly

Most recent labs
A1c (11/18/15): 6.5
TG (7/30/15): 107
TC (7/30/2015): 154
HDL (7/30/15): 37
LDL (7/30/15): 96
Cholesterol/HDL C ratio (7/30/15): 4.2

Past medical history
 # Hypertriglyceridemia: Had TG 997 in 2/15. Patient noted that he had coffee with creamer before this lab draw. Prior to that, had TG of 246 in 2/11. Most recent TG 107 in 7/15 while on gemfibrozil. Gemfibrozil d/c in 10/15.

Past Surgical History
None noted.

Social history
_____ is employed by _____ as a _____. He has smoked 1 pack per day since the age of 20 but denies alcohol or other substance use. He has worked as a _____in the past.

Family history
Unknown.

C) Overview of a Transition of Care

The patient was a 55-year-old male with multiple chronic medical conditions (outlined the FC Discharge Summary above). He worked full time as an independently contracted employee, and thus did not receive insurance benefits from his employer. His income was high enough to exclude him from Medi-Cal, but within range for significantly discounted insurance plans on the Covered California Marketplace. He was well known to the Medi-Cal Transitions Manager, who also volunteered as a Continuity Manager and had previously cared for the patient in that capacity.

On interview, the patient stated his primary barriers to transition were financial (previously unable to afford private insurance) and logistical (did not know much about Covered California or how to enroll online). He was, however, motivated to obtain insurance. In the Open Enrollment period, the patient and the Medi-Cal Transitions Manager purchased a suitable plan on CoveredCA.com during a pre-existing Free Clinic appointment. Using the online map, a new clinical home was selected, and the manager scheduled the patient's first appointment.

The manager joined the patient for his first appointment at the new clinic. The manager helped the patient complete necessary paperwork and provided the patient's new physician with a Free Clinic Discharge Summary, which was prepared in advance. The patient was happy with this new arrangement. He remained happy during follow-up phone calls one, three, and five months later. He has not returned to Free Clinic for further care since he transferred to a new healthcare system.

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